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Management Alert

DOL Issues Proposed Revisions to Disability Plan Claims Regulations

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The Department of Labor published proposed changes to its regulations governing disability claims and appeals in the Federal Register on November 18, 2015, and invited comments. The stated purpose of the proposed changes is to strengthen the current disability claims rules primarily by adopting certain procedural protections and safeguards applicable to group health plans under the Affordable Care Act.

The proposed regulations make several substantive changes to the existing regulations applicable to disability claims and appeals:

- To ensure the independence and impartiality of claims and appeals decision-makers, any decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based on the likelihood that the individual will support a denial of benefits.
- Adverse benefit determinations must:
    - Include a discussion of the decision, with the basis for disagreeing with the views or decisions of any treating health care professionals or other payers of benefits who granted the claimant's similar claims (including disability determinations by the SSA);
    - Include the plan's specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such plan rules, guidelines, protocols, standards or other similar criteria do not exist;
    - Include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim (previously, this statement was only required for adverse determinations at the appeals stage); and
    - Be provided in a culturally and linguistically appropriate manner.
- A plan's disability claims procedures must:
    - Allow a claimant to review the claim file and present evidence and testimony during the claims and appeals process;
    - Provide that, before an adverse determination on review is made, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is given, in order to give the claimant a reasonable opportunity to respond before that date; and

    - Provide that before a plan administrator can issue an adverse benefit determination on review based on a new or additional rationale, the plan administrator must provide the claimant, free of charge, with the rationale. Such rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date.
- Failure to establish or follow claims procedures consistent with the new (and existing) requirements will result in the claimant being deemed to have exhausted the administrative remedies under the Plan and entitled to pursue any available remedies under ERISA §502(a), unless the violation is *de minimis*. The claim or appeal will be deemed to have been denied on review without the exercise of discretion by an appropriate fiduciary. *De minimis* errors are those that:
    - Do not cause, or are not likely to cause, prejudice or harm to the claimant;
    - Were violations for good cause or due to matters beyond the control of the plan;
    - Occurred in the context of an ongoing, good faith exchange of information between the plan and claimant; or
    - Are not part of a pattern or practice of violations by the plan.

In the event of any error, the claimant may request a written explanation from the plan, including a specific description of the plan's bases, if any, for asserting that the error is *de minimis* and should not result in deemed exhausting of administrative remedies. The Plan must provide this written explanation, if requested, within 10 days. The claimant may then decide whether or not to pursue remedies under ERISA §502(a). If a court rejects a claimant's request for immediate review on the basis that the Plan's error was *de minimis*, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the court's decision, and the plan must provide the claimant with notice of the resubmission within a reasonable period of time.

- The term "adverse benefit determination" will include any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

These proposed regulations, if finalized, will change the manner in which disability claims and appeals are processed. Employers who handle disability claims and appeals internally will need to re-evaluate their existing procedures and tailor them to the new requirements. Even employers who utilize third-party administrators for disability claims and appeals will need to work with their third-party administrators to ensure that any necessary changes are incorporated into existing procedures.

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